GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

REFERRAL FORM FOR DME MEDICAL ASSISTIVE DEVICES AND SERVICES (DME MADS)

Instructions: This form is to be used in conjunction with the Beneficiary, their family, or Authorized Representative and may be used to request either Personal Emergency Response System (PERS) services or a Medication Management Device (MMD) services (or both services simultaneously).

□ New Referral □ Reauthorization of Existing Services □ Transfer Request

Beneficiary Information

Beneficiary Name: _____ Medicaid ID: _____ Program Code: _____

Address: _____ Telephone Number: _____

_____ Date of Birth: _____

Beneficiary's Physician: _____ Physician Telephone: _____

Special Notes for Installation:

_____

Provider Selection (select 1): □ Guardian – 068565892 □ Link to Life – 037965419 □ Philips – 027850295

Service Selection: □ Landline PERS □ Wireless PERS □ Mobile PERS □ Medication Management Device
(select all that apply)

Referral Information

Referrer's Name: _____ Telephone Number: _____

Relationship to Beneficiary: _____

Has this person been assessed with the interRAI HC in the last 90 days? Yes No

If no, is clinical documentation to justify the referral attached? Yes No

Provider Acceptance

Date 719A form submitted: _____ Authorization Number: _____

Service Start Date: _____

Please submit this form to an approved DME MADS provider via secure email to the following:

- Guardian: sf-hc@guardianalarm.com
- Link to Life: Referrals-CST@bestbuy.com
- Philips: governmentservices@philips.com